Appendix B

DIVISION OF CORRECTION

SUBSTANCE ABUSE DATA

FY 1981, July-December

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I. At both the Reception Center for men (RDCC) and the Women's Institution (MCIW) Addictions Program Staff attempt to test and interview every new admission. Space and logistics generally make this impractical: and, the increasing numbers of men who are "walk throughs" (in only 24 hours or less), and are admitted to other facilities.

II. Admissions and Testing

Compared with FY 1980, our capacity to reach new admissions for testing has diminished at the rate of 50 percent. As indicated in the paragraph above, logistics and overcrowding are impacting negatively, profoundly on these services.

TABLE I

*ADMISSION AND SUBSTANCE ABUSE SCREENING, RDCC

Month	Admissions	Mortimer/Filkins Test	Percent
July	353	203	57.5
August	448	103	23.0
September	328	231	70.0
October	383	169	44.0
November	350	143	40.6
December	404	103	25.5
TOTALS	2266	951	42.0

*Mortimer/Filkins administered only to people admitted directly to RDCC; "walk thru" from Pre-Release Units, County Facilities, and Patuxent are not tested.

REPORT

TASK FORCE ON ADDICTIONS

AND THE CRIMINAL JUSTICE SYSTEM

January, 1982

I. INTRODUCTION: THE "MISSION" OF THE TASK FORCE

Governor Hughes created this Task Force on June 23, 1981, and directed it to:

> "1) Examine the criminal justice system in terms of availability of addiction rehabilitation/ treatment, with particular attention to the points at which intervention for addiction control may take place.
>
> 2) Identify the responses that might be made at each point and, if appropriate, recommend criteria for action.
>
> 3) Recommend steps to facilitate information transfer so that any decisions for individuals are made on the basis of available knowledge.
>
> 4) Recommend any changes in site, kind or source of services and any changes in law or regulation that are suggested by this examination."

Warned that new State resources to address problems of addiction were unfortunately not available and that it was necessary "to make the best use of what we have," the overall goal assigned to the Task Force was "to recommend ways by which the agencies concerned can increase cooperation through cost, personnel and facility sharing and by other means to provide the most effective addiction treatment and rehabilitation for those persons who become the responsibility of the criminal justice system."

The Task Force was instructed to limit its work to the adult criminal justice system and not to deal with the juvenile system.

II. NATURE OF THE PROBLEM

In order to solve a problem, it is first necessary to understand it, and that includes some appreciation of its magnitude. The following few statistics will help to put the problem in a proper perspective:

(1) In calendar year 1980, 5,189 persons were committed to the Division of Correction (DOC). In the first ten months of 1981, 4,820 persons have been so committed. As of December 2, 1981, the total DOC inmate population was 9,245 (including 108 "backed up" in local jails).

(2) In calendar year 1980, 2,842 persons were released on parole; an additional 25,569 persons were placed on probation following one or more criminal convictions. For the first ten months of 1981, the parole and probation intake was 1,696 (parole) and 22,818 (probation), respectively. As of October 31, 1981, the Division of Parole and Probation (DPP) had 36,823 persons under active parole or probation supervision.

(3) On the basis of data collected since 1976, DOC estimates that about <u>one-half of its male intake and about 55% of its female intake has a significant substance abuse problem</u>. Even more alarming is the fact that, of those persons diagnosed as having a significant substance abuse problem, <u>over 55% admitted being intoxicated by alcohol or drugs at the time they committed</u>

the offense for which they were incarcerated.[1]

(4) DPP reports about the same percentage of substance abusers among its clientele. In FY 1981, about 25% of its intake (9,100 persons) was subject to a "special condition" in the court or parole order requiring a substance abuse treatment program. Of these, about two-thirds (6,500) required treatment for alcohol abuse; the other third (2,570) were diagnosed drug abusers. The Director of DPP and field personnel from that agency have expressed the belief, based on experience, that at least double that number (one-half the total active caseload) may actually have a significant substance abuse problem. If that is true, it means that each year some 9,100 persons are placed on probation or parole with the court

1. The DOC study from which these figures were taken (Preliminary Needs Assessment For Addiction Services) is appended to this Report as Appendix I. The incidence of substance abuse revealed therein, both in terms of the inmate population generally and intoxication at the time of offense, is consistent with what other studies have shown. The 1979 Report of the (Maryland) State Advisory Council on Drug Abuse estimated that about two-thirds of the male commitments to DOC during FY 1978 "reflected some kind of substance abuse problem." A 1980 report by the United States Department of Justice, based on a 1978 survey of convicted inmates in the nation's local jails, stated that about 20% "had been under the influence of drugs at the time they committed the crime that led to their incarceration, and 28 percent had consumed heavy amounts of alcoholic beverages." About 40% of those inmates had been addicts or daily users and another 8% had used drugs at least weekly. See Profile Of Jail Inmates: Socio-demographic Findings From The 1978 Survey Of Inmates Of Local Jails, National Prisoner Statistics Report SD-NPS-J-6, NCY-65412 (October, 1980), pp. 8, 17.

A study of 1978 State correctional inmates, also conducted under the auspices of the Department of Justice, revealed that 61% of the 191,400 inmates surveyed (116,500) reported having used drugs; nearly half of the 116,500 reported using heroin, cocaine, amphetamines, or barbiturates, and nearly all reported using marijuana. Of those reporting drug use of some type, 43% stated that they were under the influence of drugs at the time of the offense. See Sourcebook of Criminal Justice Statistics 1980, Table 6.21, p. 500, taken from Survey of Inmates of State Correctional Facilities 1974, National Prisoner Statistics Special Report SD-NPS-SR-2 (1976), pp. 24, 25, 27. See also Criminal Behavior of Adolescent Nonheroin Polydrug Abusers in Drug Treatment Programs, Santo, Hooper, Friedman, and Conner, Contemporary Drug Problems, Fall, 1980, pp. 301, et seq.

or paroling authority (as the case may be) being unaware of the person's substance abuse problem.

(5) A recent study of 237 male heroin addicts from Baltimore revealed that, over an eleven-year period, these men committed more than 500,000 crimes (excluding drug use and possession):

> "One of the major findings of this study was that heroin addicts commit a staggering amount of crime and that this continues fairly much on a daily basis for years and decades....
>
> The research findings... show that the average addict has committed one or more crimes during some 2,000 days. Taken together, these 237 male opiate addicts have been responsible for committing more than 500,000 crimes during an eleven year risk period. The exact figure is 473,738 crime-days, but this does not include multiple offenses committed on a given day, so the figure of 500,000 crimes is an underestimate. In this regard, it should be noted that theft was the principal type of crime committed and that drug use or possession were not, themselves, classified as crimes.
>
> This high frequency of criminality among opiate addicts is similar to that which has been reported by other investigators...."[2]

These figures merely serve to quantify to some extent what many studies have revealed and what has long been known to

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2. The Criminality Of Heroin Addicts When Addicted And When Off Opiates, Ball, Rosen, Flueck, and Nurco, published in The Drugs-Crime Connection, Inciardi, ch. 2.

police, judicial, and correctional personnel: (1) that there is a definite, demonstrable, correlation between substance abuse and criminal activity; and (2) that the problem is far worse than most people think.

It is clear, and really beyond cavil, that the overall cost to society of failing to provide adequate treatment for substance abusers, in terms of both the damage done by their criminal behavior and the expense of catching and recatching, processing and reprocessing, incarcerating and reincarcerating, supervising and resupervising them, is simply immense. It far exceeds the cost of adequate treatment.

III. PRESENT EFFORTS

DOC attempts to screen all inmates coming into the Reception and Diagnostic Center (RDC) or the Maryland Correctional Institution for Women (MCIW) through administration of the Mortimer-Filkens Questionnaire and, if the result of that is positive, through personal interview.[3] In point of fact, however, not all inmates are screened. According to DOC, in FY 1980, less than 62% of the male intake was screened, and in FY 1981 only about half the male intake was screened. See DOC Preliminary Needs Assessment For Addiction Services, attached hereto as Appendix I. The screening process, therefore, is, at best, only 50% effective.

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3. The Mortimer-Filkens is a questionnaire consisting of fifty-eight questions. A copy of it is attached as Appendix II. It was initially designed as a means of diagnosing alcoholism, but is used to detect a tendency toward drug abuse as well. See Jacobson, The Mortimer-Filkens Test: Court Procedures for Identifying Problem Drinkers, Alcohol Health and Research World, Summer, 1976, p. 22, et seq. A score of sixteen or more on the test indicates a high probability of substance abuse.

The addiction programs currently offered by DOC are summarized in Appendix I, pp. 2-4, to which the reader's attention is directed.

It is, of course, obvious that the existing programs, such as they are, are wholly inadequate. DOC recognized this itself when, on p. 4 of Appendix I, it summarized its needs and problems thusly:

> "Diagnostic Function - Insufficient staff, limited staff training, inadequate facilities, and the increasing volume of inmates entering the corrections systems clearly illustrate the need for a more uniform and better defined assessment mechanism.
>
> Treatment Function - Overpopulation and insufficient staff throughout the Division have hindered the development of a comprehensive treatment package. This is particularly apparent in the medium and maximum security facilities. Even more accute [sic] in this area, is the lack of staff to provide even the most fundamental services. This is best illustrated by the fact that several community-sponsored programs have ceased operation due to the Division's inability to provide on-site accordination and support.
>
> Planning Function - Due to overcrowding and reduced resources in all program areas, it has been impossible to design a comprehensive support system for any treatment function.
>
> Followup Function - Staff shortage and overcrowding have also potentiated the problem of providing adequate referral services for inmates leaving the Division to community resources for continued treatment as needed."

The purpose of this Report is not to condemn the present system but to improve it; we point out the problems and shortcomings in order to know where to begin. The TRAP program operated by the Drug Abuse Administration at the Jessup Pre-Release

Unit and the Junction-Bridge program in operation at the Central Laundry Pre-Release Unit at Sykesville have shown promise, and the Task Force proposes, in Part V, to build upon them.

The situation in DPP is not much better than it is in DOC. The agents assigned to supervise parolees and probationers have minimal training in dealing with substance abusers. If the client arrives subject to a special condition requiring substance abuse treatment, the agent can implement that condition by an appropriate referral. The problem is in detecting and dealing with those persons who may be serious substance abusers but who have not been previously diagnosed as such. In all of DPP, there is but one drug abuse specialist, attached to the criminal investigation unit in Prince George's County, able to provide assistance to those agents, or to those assigned to prepare pre-sentence investigation reports. There are five "alcohol treatment specialists" -- three in Baltimore City, one in Baltimore County, and one in Frederick County, but none in any other part of the State -- who do a variety of things ranging from training other agents to individual treatment. The Division has stated that it does not presently "possess the capability to effectively collaborate in the assessment and treatment of criminal offenders who abuse drugs and alcohol."[4]

IV. RATIONALE AND SUMMARY OF THE TASK FORCE PROPOSALS

Three basic premises underlie the Task Force's proposals: (1) the "missions" of the correctional service agencies (DOC and DPP) and the addiction agencies (Drug Abuse Administration (DAA) and Alcohol Control Administration (ACA)) are different and ought not to become confused, mixed, or diluted; (2) people committed to DOC are not, from the perspective of effective substance abuse treatment, in a fixed status, but rather are on a continuum as

4. Internal memorandum to Task Force.

they move through the system from intake to release; and (3) clear and structured lines of communications within, between, and among the various agencies having jurisdiction over the individuals in question must be established, maintained, and utilized.

The natural product of the first premise is that, to the maximum extent practicable, treatment services (including the development of prescriptive treatment plans) should be provided by DAA and ACA and not by DOC or DPP. As a result, the Task Force recommends that the personnel responsible for such treatment services, whether in the prisons operated by DOC or to persons being supervised by DPP, be provided or funded by DAA and ACA.

The second premise recognizes that the inmates coming to DOC differ from each other in many respects and will progress through the correctional system differently. It also takes account of the fact that those with medium length sentences will neither remain static in one institution nor jump quickly to a pre-release status. Their stay in the system will likely be broken down into four parts: initial entry and adjustment; serving their time; pre-release; and ultimate release, usually through commutation or parole. Both economics and common sense indicate somewhat different approaches to each of these statuses on the overall continuum.

The third premise is a natural outgrowth of the first and second. Treatment services for substance abusers have to be coordinated with other psychological, educational, vocational, and social service programs conducted within or as part of the

institutional or supervisory setting. As the inmate moves through DOC on his way to release, the different conditions that will prevail upon his release will have to be anticipated and planned for, and the institutional treatment program will have to "plug into" an aftercare program in the community to which the inmate will return. All of this will require a structured network of communication channels within DOC and DPP, between them, and between each of them and DAA and ACA.

Essentially, the Task Force recommends:

(1) A four-part program within DOC, staffed in part by DOC and in part by DAA through contractual arrangements. The four parts, briefly, are:

(a) Preliminary screening of <u>every new inmate</u> for substance abuse;

(b) Referral of all incoming inmates exhibiting a history of substance abuse to a four-week intensive program operated by DAA at the DOC Reception and Diagnostic Center (or, for women, at the Maryland Correctional Institution for Women (MCIW) in Jessup). The function of this program will be, primarily, to assist the prisoner in adjusting to prison life without the need for drugs or alcohol and to develop a prescriptive treatment program during (and after) the period of incarceration;

(c) Designation of a coordinator in each DOC institution to coordinate and supervise self-help groups and outside resources within the institution, monitor the treatment plans for those inmates having them, coordinate substance abuse therapy

with other vocational or therapeutic services available to the inmates, and serve as a "resource" to both DOC personnel and the inmates, both generally and for such things as "crisis intervention";

(d) Creation of two intensive (12- and 26-week) counseling programs at the Sykesville Laundry Center to prepare inmates having substance abuse programs for ultimate release and to provide for their smooth transition into aftercare community programs.

(2) A formal and structured liaison between DPP and the substance abuse agencies (DAA and ACA) whereby trained individuals from (or under contract to) those agencies will be made available (a) through workshops or other methods, to give better training to DPP agents in how to spot and deal with substance abuse problems; (b) upon call, to assist DPP agents assigned to prepare pre-sentence investigation reports in evaluating suspected problems of substance abuse and, if probation appears possible, help to frame a clear, proper, and workable "special condition" for the court's consideration; and (c) to assist agents assigned to supervise probationers and parolees in the management of substance abusers.

Each of these components, for both DOC and DPP, are described in greater detail in Parts V and VI. The total net additional cost of the entire program recommended by the Task Force is estimated to be approximately $286,000 a year, plus a one-time start-up cost of approximately $35,000.

V. DIVISION OF CORRECTION

A. PRISONER IDENTIFICATION AND EVALUATION

The Task Force recommends that, as part of the classification process, each new inmate committed to DOC be tested for substance abuse. At present, this can be done initially with the Mortimer-Filkens test. Anyone scoring positive on the Mortimer-Filkens test would then be interviewed individually by a substance abuse counselor to determine whether (1) a substance abuse problem really exists with the inmate, and (2) if so, the kind, scope, and intensity of the problem.

The screening is thus a two-part process: the test and, if the test is positive, an individual interview with a trained counselor. For male inmates, the screening would be done at RDC; for female inmates, it would be done at MCIW.

Assuming a gross male intake of 5,200 (100 a week) and a 50% positive showing, DOC estimates a need for two full-time counselors to administer the test and conduct the interviews.[5] There is, at present, one counselor performing this function (which, in part, is why only half the incoming males are screened). DOC estimates an annual budget for this program of $40,145, as follows:

(1) Salary (two counselors)	$29,510[6]
(2) Fringe (approximately 21% of salary)	6,135
(3) Test and materials	4,500
TOTAL	$40,145

5. The Mortimer-Filkens takes about forty-five minutes to administer and evaluate, but it can be given to prisoners in groups, The individual interviews take thirty to forty minutes which, assuming the need to interview approximately fifty inmates a week, would require about thirty to thirty-five hours. Two counselors would have seventy-one hours a week (thirty-five and a-half hours each) available for testing, interviewing, and adjunctive duties.

6. DOC anticipates that these two positions would be at a Grade 9 (Classification Counselor I) level, with a starting, Step 1, salary of $10,948. The extra sum, over the $21,896 indicated for that grade, is due to the fact that the current DOC employee performing that job is a Senior Classification Counselor at a Grade 14. He would be retained in that position.

The program envisioned for women at MCIW is described in Part E.

B. STABILIZATION AND ADJUSTMENT PROGRAM

The Task Force recommends the establishment at RDC and at MCIW of a special four-week stabilization and adjustment program. Each new inmate found through the initial screening process to have a significant substance abuse problem would be placed in that program and, except in the most unusual circumstance, would be required to complete it. A new "class" would start each week and would remain more or less intact for the four-week period.

The primary therapeutic focus of the program would be to assist the inmate in adjusting to prison life (and to life in general) without the need of drugs or alcohol. The program would include discussion and counseling in:

a. Orientation to prison life, facilities and resources.

b. Definition of stress and how people handle stress including reliance on drugs and alcohol.

c. Projection of specific stress to be encountered during imprisonment.

d. Acceptable stress management techniques for the person in the prison settling.

e. Definition and explanation of services available during the total period of incarceration to help with stress.

f. Orientation to drug abuse and alcohol treatment with definition and explanation of treatment services available and how to use them.

The Task Force recommends emphasis on stress management techniques because that seems to be the therapy most recommended at present; however, the Task Force is advised that other treatment

modalities may also be effective in this type of setting. We therefore suggest that the program be monitored and evaluated periodically for its effectiveness, and that other techniques be introduced if they are found to be helpful. See Part G, infra.

A second, equally important, function of this program is the development of a proposed substance abuse treatment plan for the inmate, covering at least the entire expected period of incarceration and, to the extent possible, a post-release period as well. Such a treatment plan would naturally have to be coordinated with overall classification decisions, including any MAP contracts under negotiation, in order that it (1) is supportive of and not contrary to other, equally important, rehabilitation plans, and (2) is possible of implementation. Though specific enough to be meaningful, the plan must, of course, be flexible to allow for needed modification.

In terms of agency responsibility for the implementation of this stabilization and adjustment program, the Task Force recommends:

(1) DOC should be responsible for overall case management of inmates in the program. This is to include connecting the inmates with the appropriate treatment personnel in the institutions to which they will be transferred upon leaving RDC.

(2) DAA, through contractual arrangements, should provide and fund the personnel and other resources necessary for the actual counseling and treatment.

The program itself would consist, for each inmate in it, of two two-hour group sessions and one one-hour individual therapy

session each week for the four weeks, plus whatever other counseling he may receive as part of the classification process.

Based upon a current (FY 1981) annual DOC intake of 5,200 (100 per week) and the estimate that about half of the incoming inmates will have a significant substance abuse problem, DOC and DAA project that about forty-eight persons per week, or 195 per four-week period, will be found eligible for participation in the stabilization and adjustment program. That would involve:

(1) 13 groups of 15 inmates x 2 group meetings/ week = 104 group sessions x 2 hours/session = 208 hours;

(2) 195 clients x 1 hour individual counseling/week x 4 weeks = 780 hours;

(3) Reporting and preparation time, estimated at 1 hour per inmate per 4-week period = 195 hours.

A program of this magnitude, involving approximately 1,173 hours a month (208 + 780 + 195), would require eight counselors, each to handle, on the average, 142 hours per 4-week period (35.5 hours per week x 4 weeks = 142 hours).[7] It would also require, as support, one secretary and one supervisor.

The estimated annual budget for the program, to be funded by DAA, is as follows:

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7. The multiplication comes up a bit short (8 x 142 = 1136) in terms of the estimated need (1,173 hours), but not enough to justify another counselor. Some overtime arrangement may have to be written into the DAA contract.

(1) 8 counselors at $14,000 (contracted)[8]	$112,000
(2) 1 supervisor at $18,000 (contracted)	18,000
(3) 1 secretary at $10,000 (contracted)	10,000
(4) miscellaneous materials	1,460
(5) travel (estim. 3,000 mi. at 18 cents)	540
TOTAL	$142,000[9]

We note that DOC is estimating an increase in its annual intake from 5,200 to 5,800. If that occurs, an additional ten to twelve inmates a week may have to be accommodated, requiring possibly two additional counselors.

C. MAINTENANCE PROGRAM -- CONTINUING ADDICTION TREATMENT

This is the middle phase of the overall DOC program -- that designed to assist the inmate while he is "serving his time." Ideally, perhaps, that phase of the program should also be intensive; but the point of diminishing return would quickly be reached, and the efficient use of scarce resources militates against a high-cost program during that phase. An inmate may be locked up for several years, and it is simply not feasible at present to operate an intensive structured program for 4,000 to 5,000 inmates for that period.

The most efficient and beneficial use of State resources can be achieved, we think, by concentrating them at the entry and

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8. The counselors' salary is equivalent to that of Counselor IV ($11,700) plus fringe.

9. There may be some initial start-up costs for telephone installation, furniture, equipment, etc. DOC and DAA estimate such costs will not exceed $20,000. No costs for ongoing utilities and supplies are included. It is expected that those services will be provided by DOC at minimal cost; if there is some additional cost, it will be reflected in the DOC annual budget.

release points. That is not to say, however, that the inmate should be left to "fend for himself" during this long and difficult period. Quite the contrary.

The Task Force believes that the most efficient modality for this middle period is to take maximum advantage of existing outside resources and self-help groups within the institution, which, as noted, is the current philosophy. A number of these resources and groups exist throughout the State and the various institutions, although some, unfortunately, have "folded" or are about to "fold" or restrict their activities because of fiscal constraints. We see the need to strengthen those resources and to ensure their most efficient utilization.

The Task Force recommends that in each of the major DOC institutions there be designated an addiction treatment coordinator, whose function will be:

(1) to review and monitor treatment plans prepared as part of the stabilization program;

(2) to act as liaison with community groups and facilities able to provide services within the institution, to develop agreements with such groups for those services, to publicize the availability of those services; and to arrange for and coordinate the actual provision of those services;

(3) to act as liaison with DAA and ACA, and also with the mental health, medical, and social service units of DOC in order to coordinate addiction treatment with the services provided by those units;

(4) to provide limited individual counseling on an emergency basis ("crisis intervention");

(5) to work with and provide guidelines for leaders of self-help groups;

(6) to act as liaison with his/her counterpart in any other DOC institution to which an inmate may be transferred, and especially with the pre-release program at Sykesville;

(7) if parole or other release of an inmate without transfer to Sykesville is likely, to assist in the development of an aftercare plan, and to act as liaison with DPP and the necessary community resources to help assure the implementation of that plan; and

(8) generally to be available as a "resource" to the inmates and correctional personnel at the institution on matters pertaining to substance abuse.

Because these counselors will exercise primarily a coordinative rather than a treatment function, they should be DOC employees. They should, however, be devoted exclusively to the tasks noted above and should have no other correctional duties.

Based on DOC data, the Task Force estimates that eleven counselors will be required in order to staff this segment of the program, one each at RDC,[10] the Penitentiary, the House of Correction, the Annex at Jessup, Brock Bridge, MCTC, MCIH, and MCIW, and three for the pre-release centers. The expected budget for the maintenance phase is estimated as follows:

10.A "maintenance" counselor is required at RDC because a number of inmates, unfortunately, remain there for extended periods, and also because a number of inmates are released directly from RDC into the community, and someone has to coordinate an aftercare plan for such individuals.

(1) Salary (11 counselors)	$149,304[11]
(2) Fringe (approx. 21% of salary)	32,188
(3) Equipment	4,200
(4) Training and consultant fees	3,300[12]
TOTAL	$188,992

As is the case with the Stabilization program, some minimal support services may be required, but DOC and the Task Force believe that they can be provided by existing DOC staff and with existing resources.

D. REENTRY (PRE-RELEASE) PROGRAMS

We have already alluded to the TRAP program at Jessup and the Bridge program at Sykesville, both being joint efforts by DOC and DAA to assist known substance abusers who are in a pre-release status. These programs appear to be worthwhile, although it has been suggested that TRAP could be improved if the inmates in it had a structured work program and a closer liaison with DOC, which is presently lacking.[13]

What the Task Force proposes, essentially, is to center both programs at the Central Laundry Camp, and indeed to commit that facility entirely to those programs. That will allow for a greater efficiency in operation and a better structured overall program.

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11. DOC presently has seven counselors, at various salary grades and steps, that it proposes to use in this program. For any new personnel, the job classification would be Classification Counselor I at salary grade 9.

12. Both the new personnel and, to some extent, the existing personnel will need some training in order to carry out their function. That is what this item represents.

13. Both programs are operated by Junction, Inc., a nonprofit company, under contract with DAA.

Both programs -- one a twelve-week and one a twenty-six-week program -- would be voluntary, although they could, and likely would, be a component in some MAP contracts. The shorter program (Reentry I) would be modeled after the present Bridge operation. It would accept those inmates whose substance abuse history has been minimal to medium, but who are not "hard core" addicts. Basic eligibility criteria based upon behavior while in prison, personality traits, expected living arrangements after release, prospective employment opportunities, and the like would be developed.

The longer, twenty-six-week, program (Reentry II) would be for the more serious substance abusers. Modeled on the current TRAP program, it would accept those inmates with a history of long incarceration, heroin addiction, aggressive behavior, repeated offenses, and unemployment.

Although these reentry programs are envisioned as part of a continuum of treatment, only a fraction of the inmates diagnosed upon intake as having a significant substance abuse problem will actually be available for the reentry programs. DOC statistics indicate that about 37% of those inmates diagnosed at intake as having a substance abuse problem arrive with sentences of two years or less. As the result of early parole or commutation, industrial and "good-time" credits, and early placement in work-release centers, these people generally are not in the system long enough to take advantage of the reentry programs.[14] A number of

14.DOC statistics show that, as of July 31, 1981, only 11.6% of the general DOC population had sentences of two years or less (the corresponding figure for June 30, 1978, was 11.2%).

others, entering with longer sentences, also get released early, through parole or court order,[15] or find themselves ineligible for entry into pre-release programs.

By reason of these "washouts" and "ineligibles," DOC anticipates a potential for the two programs of about 700 inmates a year. Based on DOC inmate profile statistics and the track record of Bridge, it is estimated that about 560 inmates would be eligible and would apply for treatment in the Reentry I program, which would allow for staggered twelve-week sessions of 140 persons each per year. The DOC statistics and the TRAP program experience indicate that about 120 persons would be eligible and would apply for the twenty-six-week Reentry II program. That would allow two sessions per year with sixty inmates per session.

This anticipated caseload would suffice to fill the Laundry Center. The inmates in these programs would operate the laundry, giving them a forty-hour work week. The therapy would supplement the important occupational component, and would take place in the evenings and, to some extent, on weekends.

The two programs, cast as twelve and twenty-six weeks, respectively, each allow for orientation and adjustment periods of one week in the beginning and one week at the end. Active therapy, therefore, is based on ten- and twenty-four week periods.

Reentry I would involve four hours of counseling a week,

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15. DOC reports that in FY 1981, 520 inmates were released pursuant to court order. The figures do not indicate the nature or reason for the court order.

or a total of forty hours for the ten-week period. Half of that would involve group counseling relating to substance abuse; the other half would involve job counseling -- how to get and keep a job. This type (and extent) of therapy has apparently been successful. DAA statistics show a recidivism rate for "alumni" of Bridge, upon which Reentry I is based, of 12.8% over a four-year period, as compared with about 36% for the general DOC population. The Bridge program is based on three hours a week; Reentry I would expand that to four hours a week.

Reentry II, dealing with the more difficult abuser, would be more intense. It would involve a comprehensive program of group and individual substance abuse counseling sessions, behavior modification, job-readiness counseling, and basic adult education. Altogether, the participant would spend nearly twelve hours a week in class and counseling sessions -- three hours a night, four nights a week.[16]

The counseling and therapy under both Reentry programs would be provided by contractual personnel during the evening hours. DAA estimates a basic contract cost for counseling services of $6.50 an hour, which is consistent with its present arrangements with Junction, Inc. All expenses relating to the operation of the facility itself would, of course, be included in the DOC budget and would not be considered as expenses of the Reentry programs.

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16. The components of the program are (1) three and a-half hours group and individual substance abuse counseling; (2) one and a-half hours a week behavior modification counseling, using "non-traditional" techniques -- transcendental meditation, etc.; (3) forty-five minutes a week job-readiness counseling; and (4) six hours a week basic adult education.

In order to provide for a continuity of operation at the Laundry Center, the inmates in both Reentry programs would be in staggered groups. Reentry I, involving an average daily population of about 140, could, for example, be based upon twelve groups of eleven to twelve inmates each, with a new group starting every four weeks. Similarly, Reentry II, involving an average daily population of sixty, could be based upon five groups of twelve inmates per group, a new group starting every four, six, or eight weeks. Such an arrangement would avoid large influxes or departures at one time and would provide for an even flow of inmates through the program.

There are, of course, a number of ways in which the scheduling can be arranged, and, to some extent, the funding requirements will depend on how it is done. With respect to Reentry I, if one views the program in the context of staggered twelve-week units, an annual cost for direct therapy service (i.e., excluding administration costs) of about $15,000 is envisaged. This is calculated as follows:

(1) For each group, 2 sessions/week x 12 weeks = 24 therapy sessions x 2 hours/session = 48 hours for the 12-week session

(2) 48 hours/group x 12 groups = 576 hours for a 12-week session for 12 groups

(3) 576 hours/session x 4 sessions = 2,304 hours annually

(4) 2,304 hours x $6.50/hour = $14,976.

Because the groups will be staggered, they will be operating fifty-two weeks per year and not forty-eight (as assumed

by multiplying twelve week sessions by four). However, at any given time during the year, it is likely that two of the twelve current groups will not be in active group therapy; one will be in the opening week orientation and one will be in the wind-up phase. We therefore believe that the estimate of $14,976 for direct cost is reasonable.

Based on current experience with the Bridge program, DAA estimates that for each dollar spent on direct therapy, an additional $2 is needed for support and ancillary services. Half of this -- one hour of a counselor's time for each hour he spends in direct counseling -- is for preparation and reporting; the other half is for ancillary costs -- typing, materials, travel, etc. That would add an additional $29,952, for a total cost (excluding administration) of about $45,000 ($44,928).

The cost of Reentry II can be figured on essentially the same basis, although it might be more prudent to calculate it on the basis of fifty-two weeks rather than forty-eight weeks. Although the groups will likely be staggered, because of the longer (twenty-six week) session there will be proportionately less "dead" time -- winding up and winding down; moreover, inasmuch as the program is more intensive, there will likely be a greater need for special intervention. On that basis, the cost of Reentry II may be estimated as follows:

(1) Group Substance Abuse counseling: 780 hours (2 sessions/week x 1.5 hours/session = 3 hours/week x 52 weeks - 156 hours/group x 5 groups = 780 hours);

(2) Individual Substance Abuse counseling: 1,560 hours (1 session/week x 0.5 hours/session - 0.5 hours x 52 weeks = 26 hours/person x 60 persons = 1,560 hours);

(3) Behavior Modification counseling: 390 hours (1 session/week x 1.5 hours/session = 1.5 hours/week x 52 weeks = 78 hours/group x 5 groups = 390 hours);

(4) Job-Readiness counseling: 195 hours (1 session/week x .75 hours/session = .75 hours/week x 52 weeks = 39 hours/group x 5 groups = 195 hours);

(5) Adult Basic Education: 1,560 hours (6 hours/week x 52 weeks = 312 hours/group x 5 groups = 1,560 hours);

(6) Total hours/52 weeks: 4,485 (780 + 1,560 + 390 + 195 + 1,560 = 4,485) x $6.50 per hour = $28,952.

As with Reentry I, there would have to be added to the direct counseling cost of $28,952 a like amount for preparation and reporting or a total of $57,904.

Based on its current experience with Bridge and TRAP, DAA estimates an annual administration and supervision expense of $97,600, broken down as follows:

(1)	Project Director	$ 22,000
(2)	Secretary	11,000
(3)	Bookkeeper/clerk	14,000
(4)	Clinical Supervisor	15,000
(5)	Total Staff	$ 62,000
(6)	Fringe at 20%	12,400
(7)	Total	$ 74,400
(8)	Travel	5,000
(9)	Supplies	2,000
(10)	Miscellaneous	10,000
(11)	Indirect costs (10% of salaries)	6,200
(12)	Total	$ 97,600

An additional, one-time cost of $15,000 is projected for start-up costs. That includes primarily furniture, equipment, and telephone installation.

An integral part of the Reentry programs is coordination with the community-based programs to which the inmate will be referred upon release, as well as tracking the inmates and evaluating the success of the program. That requires a tracking and evaluation unit consisting of:

(1)	Two trackers (contractual) at $13,000 each	$26,000
(2)	Two community liaison and validation personnel (contractual) at $13,000 each	26,000
(3)	Secretary (contractual) at $10,000	10,000
(4)	Supplies and equipment	12,000
	TOTAL	$84,000

The total estimated cost of the Reentry programs, based on the above calculations, is $284,432:

Reentry I		$ 44,928
Reentry II		
Direct	$57,904	
Administration	97,600	
Tracking and Evaluation	84,000	239,504
TOTAL		$284,432

E. PROGRAM FOR FEMALE INMATES

As noted in Part II of this Report, the incidence of significant substance abuse among the State's female prisoners,

in terms of percentage, is as bad as it is for males. There are, however, far fewer female prisoners, and they are all housed at MCIW.

DOC statistics show, for FY 1981, a female inmate intake of about 250, of whom about 55% had a significant substance abuse problem. Assuming those figures remain fairly constant, there would be about 140 women prisoners requiring addiction treatment. That means about fourteen per month.

Security and logistics dictate that the program for women be conducted at MCIW -- that the female prisoners not be mixed with the male inmates at RDC or the Laundry Center.

It is anticipated that one full-time additions counselor working closely with a DOC addictions specialist could provide intake, continuing and reentry programming for the relatively small group at MCIW.

Because of the variety of programming needed to be delivered by one person, it is recommended that:

1. The addiction counselor be paid at $22,182 including fringe.

2. The DOC addictions specialist be of comparable grade level.

3. The addiction counselor be an employee of the same firm delivering services for the male institutions so that tracking evaluation and community liaison will be built in.

4. The addiction counselor have an extended experience in counseling and a full knowledge of the correctional system.

This program would require:

1.	One addiction counselor at	$22,182
2.	One addiction specialist at	22,182
	TOTAL	$44,364

F. SUMMARY OF ANTICIPATED COST OF DOC PROGRAM

1. Gross Cost of Program

(a)	Screening program at RDC	$ 40,145 (DOC)
(b)	Stabilization program at RDC	142,000 (DAA)
(c)	Maintenance Program	188,992 (DOC)
(d)	Reentry programs at Sykesville	284,432 (DAA)
(e)	Full program at MCIW	44,364 (1/2 DOC 1/2 DAA)
	TOTAL	$699,933[17]

2. Current (FY 1982) Funding for Existing Programs

(a)	DOC	$185,121
(b)	DAA	228,836
	TOTAL	$413,957

3. Additional Funds Required

(a)	Gross Cost	$699,933
(b)	Current Funding	413,957
	NET NEED	$285,976

DOC	$ 66,198
DAA/ACA	219,778
	$285,976

G. IMPLEMENTATION AND EVALUATION OF PROGRAM

The proposals contained in this Report provide only the basic structure or outline of actual programs. The success of the programs will necessarily depend on how they are implemented.

17. Excludes total estimated start-up cost of approximately $35,000.

We are dealing with a difficult problem, a difficult population, and a "state of the art" that is by no means perfect. It is especially important, therefore, that precise (but flexible) operating procedures be developed by DOC, DPP, DAA, and ACA, and that they, and the program as a whole, be reviewed periodically.

If the Task Force proposals are adopted, the affected agencies, as soon as possible, should develop a set of operating procedures and then see to it that they are adequately explained to both the agency personnel who will be involved in implementing the program and the inmates.

The Task Force also suggests that, within sixty days after the end of the first year of operation, the affected agencies prepare a written evaluation of the program for submission to the Secretaries of Public Safety and Correctional Services and Health and Mental Hygiene. The report should delineate any problems or shortcomings with the program and any recommended changes, and should address the broader question of whether the program should be continued.

VI. PAROLE AND PROBATION

As noted in Part III, ante, DPP does not have a sufficient cadre of trained personnel among its agents to provide direct treatment services to its clientele. Nor, in the opinion of the Task Force, should it attempt to provide those services except in the most minimal manner as part of its general investigative and supervisory work.

There is a need for all agents, whether investigative or supervisory, to have a good basic grounding in how to detect substance abuse problems among their clients and where to turn for assistance in dealing with those problems.

A special need in this regard is in the preparation of pre-sentence investigation reports. If a judge is going to consider probation as a possible sentencing alternative, it is critical that he know whether the defendant is an alcohol or drug abuser and, if so, how significant the problem is and what resources are available to deal with it. When one considers that about 80-85% of convicted criminals are placed on probation in lieu of incarceration and couples that with the staggering propensity for criminal conduct among substance abusers, the need for an accurate assessment becomes painfully obvious.

Even if the presentence investigation function is markedly improved, the fact is that most of DPP's intake will continue to arrive without the benefit of a pre-sentence investigation.[18]

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18. Only 7,514 pre-sentence reports were prepared in FY 1930; DPP's total probation intake in CY 1980 was over 25,000.

It is therefore to be expected that a considerable number of persons having significant substance abuse problems will continue to be placed on probation without a prior diagnosis of the problem, and with no special condition attached to the probation. That puts a burden on the supervising agent to pick up the problem and deal with it, preferably at the point of intake.

To meet these needs, DPP has proposed the following programs and procedures:[19]

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19. The DPP proposals hereinafter set forth were, in part, a response to initial recommendations by the Task Force, and came too late to be considered by the full Task Force. They were submitted to the Chairman and were discussed by DPP's Director with the Directors of DAA and ACA and with the Secretary of Public Safety and Correctional Services. Because they (1) involve procedures internal to DPP, (2) do not involve additional funding, and (3) appear to be consistent with the overall Task Force recommendations and parallel somewhat the recommended programs for DOC, the Chairman took the liberty of including them in this Report more or less as submitted by DPP.

Initially, the Task Force was prepared to recommend that DAA and ACA provide a back-up service to assist in training DPP agents and working with them in special cases. That is by no means inconsistent with the proposals set forth by DPP and ought still to be considered. This is especially important if DPP estimates as to the number of undetected substance abusers are correct. If it is true that for each of the 9,100 persons coming to it each year with a diagnosed substance abuse problem there is another person coming on the roll with an undetected problem, the ability of DPP to provide appropriate service (and the ability of DAA and ACA to provide appropriate treatment resources) will become severely strained. As these people -- perhaps an additional 9,100 a year -- are diagnosed, they too will be subjected to special treatment and monitoring conditions, taxing both DPP and the resources provided by the substance abuse agencies.

There is no way reasonably to project a cost for this. We don't know yet how extensive the subsurface problem may be. We merely think it prudent to point out the potential problem.

As with the DOC programs, it will be necessary for DPP, DAA, and ACA to develop some specific procedures for their cooperative efforts; and this should be done as soon as possible. Similarly, there ought to be a periodic systemic evaluation to see how well the overall program is being implemented.

"A. CLIENT IDENTIFICATION AND EVALUATION

A systematic screening process to identify substance abusers will be initiated at three different points as offenders come into contact with the Division of Parole and Probation:

- Prior to sentencing via Presentence Investigations
- At the point of Case Intake
- During Case Supervision

Presentence Investigations. The Division of Parole and Probation proposes to utilize existing investigation and support services personnel to screen and test all court referrals for presentence investigation reports. Agents in the Division's criminal investigation unit will be trained by the current alcohol treatment specialists and field staff possessing drug expertise to perform preliminary assessments, using state of the art techniques.

Preliminary screening for alcohol/drug abuse at this point will be administered as part of the presentence investigation. If evidence of a substance abuse problem is found, the results will be included in the PSI report along with a prescriptive recommendation for treatment intervention. A copy of the presentence report, with the results of the substance abuse screening, will accompany incarcerated offenders to the Division of Correction or local jails, and to the assigned Parole and Probation agents for those offenders placed on supervised probation.

In cases where the preliminary assessments by investigators are not sufficient for accurate identification of

substance abuse the staff specialists will conduct a comprehensive evaluation (Mortimer-Filkens Test) and submit a prescriptive recommendation as part of the PSI report.

Case Intake. As part of the interview process, Intake agents will administer the Michigan Alcoholism Screening Test (MAST) to identify possible alcohol abusers; and will utilize prior criminal records, MVA records and (to be developed) a questionnaire to screen for drug abuse in those cases not previously identified by a special condition for treatment. All agents performing case intake functions will also receive training in how to recognize basic symptoms of substance abuse. Where indicated the substance abuse coordinator will be available for case consultation and to conduct a more thorough evaluation (Mortimer-Filkens Test) on low profile substance abusers.

If the preliminary screening at Intake shows evidence of substance abuse problems in a particular case, the Intake Agent will make an immediate and appropriate referral to a treatment resource (ACA/DAA). The substance abuse coordinator will be responsible for helping to maintain an effective liaison between the Division and ACA/DAA. In instances where more comprehensive evaluations performed by the substance abuse experts result in the identification of an alcohol/drug problem, they too will make speedy and appropriate referrals to DAA/ACA for treatment.

Case Supervision. All field agents assigned to supervise parole and probation cases will be trained to administer preliminary screening tests on those cases not previously identified at the point of Intake or via a presentence investigation. The substance abuse coordinator would also be available to these agents and provide the more comprehensive evaluations (Mortimer-Filkens) where substance abuse is not readily apparent through preliminary screenings.

A special note should be made regarding the Parole process. With DOC, ACA, and DAA heavily involved in assessment, identification, and counseling activities during the institutional phase, it would seem that most substance abusers released on Parole would already be identified. DPP's experience in this area indicates that there will be parolees who do well in terms of substance abuse treatment during the institutional phase (or who may not even show symptoms of substance abuse) but who will experience problems upon return to their home/community environment. DPP's expanded assessment/identification capabilities will provide a mechanism for those individuals experiencing post-release problems to be screened and timely referred to appropriate treatment agencies (ACA/DAA). The Substance Abuse Coordinators will also function as case consultants in this ongoing parole identification/assessment/case management process.

B. CASE PLANNING AND SUPERVISION

After a parolee or probationer has been identified as having a substance abuse problem, and has been referred to ACA or DAA for treatment, the need is to develop a viable case supervision plan designed to maintain the client in treatment and to assist him/her in successfully completing supervision (i.e., finding or sustaining employment; getting a GED, job training, etc.). It is at this point that the substance Abuse Coordinator can be utilized to provide (when necessary) advise [sic] on designing a workable individualized case supervision plan. Initially, substance abuse clients would be urged to voluntarily participate in treatment. Those persons not motivated to participate would be constructively coerced with a recommendation for treatment via a special condition imposed by the Courts or Parole Commission.

The Division of Parole and Probation is committed to initiating an improved effort to identify and refer for treatment all substance abusers under its supervision. This effort will be focused upon several activities, including the training of its agent staff - 454 supervision agents, 82 investigation agents and 18 intake agents - to conduct preliminary screening procedures and make appropriate referrals for treatment. Through this process, the Division of Parole and Probation will have the front line capacity to assess and refer for treatment its high profile substance abuser population. The Substance Abuse Coordinator

will provide an in-house expertise for more detailed substance abuse evaluations and provide a mechanism for the Divison of Parole and Probation to identify its low profile substance abusers. In view of these commitments, the basic functions of the Substance Abuse Coordinators will be as follows:

1) Training all field staff who interact with substance abuse clients. Training will include identification, preliminary assessments, referral procedures, and insight into the dynamics involved in working with substance abusers.
2) Providing detailed evaluations and prescriptive recommendations for treatment, referral and supervision case planning to field staff referring individuals who mask their substance abuse or make their substance abuse difficult to detect.
3) Offer case consultation to field staff in the case management of substance abusers.
4) Act as a liaison with the treatment network to insure and facilitate effective exchanges of communication concerning the comprehensive treatment services being offered the division's clients. The coordinator will regularly meet with the treatment staff of community agencies to discuss interagency issues. Such liaison activities will serve to increase mutual understanding so that treatment plans and supervision plans are coordinated and are consistent with the case management

responsibilities of the Division of Parole and Probation."

The Division of Parole and Probation plans to utilize existing staff and resources to upgrade its substance abuser case management capabilities, and it is therefore anticipated that any additional costs will be nominal and can therefore be borne by the agency's FY 1983 Operating Budget.

MARYLAND DIVISION OF CORRECTION

PRELIMINARY NEEDS ASSESSMENT

FOR

ADDICTIONS SERVICES

Prepared for the Governor's

Task Force on Addictions and Criminal Justice

August 1981

Population Identification

In Fiscal Year 1981, 49.5% of the male inmates and 86% of the female inmates entering the Division of Correction were tested for substance abuse. Of the male population tested, using a combination of Mortimer/Filkins Questionnaire and screening interviews by the addictions staff, 25% were identified as having a substance abuse problem. (Based on data collected since 1976, it is reasonable to predict that approximately 50% of the total male population (7,952) has a substance abuse problem.) Of the female population tested, 85% were identified as having a substance abuse problem.

By standards of the Mortimer/Filkins Questionnaire, more than 75% of the substance abusing population are identified as abusers rather than addicts.

The male population abuse patterns are as follows: 18.4% - alcohol only; 36.9% - other drugs, and 27.7% - both alcohol and other drugs. The female population abuse patterns are as follows: 25.8% - alcohol only; 60.0% - other drugs, and 19.2% - both alcohol and other drugs.

Junction/Bridge - This is a program aimed at the younger abuser, using 10-week cycles of group counseling and job readiness preparation. It is staffed with a half-time director (other half-time is at TRAP), a full-time program services coordinator, and four 10-hours per week consultant/counselors. The program is located at the Central Laundry Pre-Release Unit, and accommodates 48 male inmates per 10-week cycle. The annual operating budget is $72,000.

Alcoholism Control Administration/Division of Correction Services - There are seven Aftercare Counselors trained in addictions assigned to local Health Departments—one each in Wicomico, Queen Annes, St. Mary's, and Washington Counties; and three in the Blatimore City Health Department. The former carry responsibility for regions—Lower Shore, Upper Shore, Southern Maryland, and Western Maryland; while the Baltimore City Unit is entirely for the City. These units were funded by the General Assembly in July 1978 to serve referrals from the Division of Correction Addictions Program. Services were to range from the broker function (i.e., finding treatment resources in the community) to transitional counseling and pre-release planning, both before and after release from the Division of Correction. This activity is coordinated with the Division of Parole and Probation.

Preliminary Needs Assessment

Diagnostic Function - Insufficient staff, limited staff training, inadequate facilities, and the increasing volume of inmates entering the corrections systems clearly illustrate the need for a more uniform and better defined assessment mechanism.

Treatment Function - Overpopulation and insufficient staff throughout the Division have hindered the development of a comprehensive treatment package. This is particularly apparent in the medium and maximum security facilities. Even more accute in this area, is the lack of staff to provide even the most fundamental services. This is best illustrated by the fact that several community-sponsored programs have ceased operation due to the Division's inability to provide on-site accordination and support.

Planning Function - Due to overcrowding and reduced resources in all program areas, it has been impossible to design a comprehensive support system for any treatment function.

Followup Function - Staff shortage and overcrowding have also potentiated the problem of providing adequate referral services for inmates leaving the Division to community resources for continued treatment as needed.

Current Operations: Staff and Programs

Staff

There are eleven (11) counselor positions attached administratively to the various institutions. Of these, three (3) are vacant - at the Penitentiary, Central Laudry, and Baltimore Pre-Release Unit. There is no position at the House of Correction (abolished 3/80). Also, there is a Director of Social Work and Addictions at Division Headquarters.

Program:

Maryland Correctional Institution for Women - From identification, assessment, and orientation through pre-release planning, this 250 bed unit for women is served by one (1) trained Addictions Counselor. There is a primary emphasis on group counseling and addiction education. Self-help groups and community agency programs are an integral part of the treatment services. Aftercare Counselors from Baltimore City Health Department participate regularly in pre-release planning and transitional counseling. Referral to other after-care units in other areas of the State are available.

RDCC (Reception Center-Male) - The Addictions Counselor in this facility provides an identification and assessment service which is performed as part of the orientation process. This includes group testing and individual screening interviews. Also, the Counselor is responsible for an addiction education program and referrals to all addiction counselors in the maintaining institutions.

Penitentiary - The Addiction Counselor assigned to this facility focuses on group counseling, addiction education, and coordination with substance abuse self-help groups and community programs. The Echo House Foundation, Baltimore City, has provided staff for group counseling in 12 week cycles the last two years.

Maryland Correctional Training Center/Maryland Correctional Institution - Hagerstown - There is one Addictions Counselor at each facility. These counselors use reality-oriented groups as the principal tool of intervention. They also coordinatre with self-help groups, provide pre-release counseling, and conduct addiction education groups. The Aftercare Counselor from the Washington County Health Department also participates in the pre-release planning for the Work-Release Center, which is a part of Maryland Correctional Training Center.

Maryland House of Correction - The position of Addictions Counselor was abolished March 1980. However, in an effort to provide assistance, a group of 15 inmates, all of whom were associated with either SANDS or AA self-help groups at the House of Correction, were given first level training in addictions counseling in the last fiscal year by faculty from the Office of Education for Addictions, DHMH. Of these, nine men completed training and established limited caseloads. However, the program was suspended in June 1981 due to disciplinary infractions associated with the program.

Pre-Release System (Eastern Pre-Release Unit, Southern Maryland Pre-Release Unit, Poplar Hill Pre-Release Unit, Central Laundry Pre-Release Unit, Jessup Pre-Release Unit, Baltimore Pre-Release Unit, and Pre-Release Unit for Women) - There is one counselor in each unit except Jessup Pre-Release Unit and the contractual units in Baltimore City. The major program emphasis is on individual, group, and family counselling, addiction education, and reality-oriented community reintegration.

Self-Help Groups and Community Resources

Substance abuse oriented self-help groups such as "Alcoholic's Anonymous", SANDS (Seekers After New Directions), and Seventh Step are located in all facilities except Reception, Diagnostic, and Classification Center.

Either from initiative of the community agency or the Division of Correction, cooperative services have been provided from substance abuse programs in various parts of the State as follows:

Bumpy Oaks (Southern Maryland Drug Abuse Program) - This agency initiated group counseling at the Southern Maryland Pre-Release Unit. Previously there were two groups, one at Southern Maryland Pre-Release Unit and another at Bumpy Oaks Center in La Plata.

Washington County Addictions Program - This unit provided group counseling at both Maryland Correctional Training Center and Maryland Correctional Institution - Hagerstown until Fiscal 1981 when fiscal constraints required termination.

Upper Shore Mental Health Center, Easton - Staff from the drug abuse unit provided group counseling at the Eastern Pre-Release Unit in Church Hill through Fiscal 1981. Budgetary limits have forced termination for FY'82.

Echo House Foundation - Group counseling in 12-week cycles was provided through FY'82 in conjunction with the Addictions Counselor at the Penitentiary. However, the Division of Correction counselor vacancy has caused the termination of this program.

Self Pride, Inc. - This organization of community professionals provides both pre-release and aftercare counseling and guidance to females at Maryland Correctional Institution for Women and the Pre-Release Unit for Women.

Maryland Drug Abuse Administration/Division of Correction Services

There are two major programs operated in the Division under the sponsorship of the Drug Abuse Administration. The Division provides space, security staff, and maintenance support to both programs.

TRAP (Treatment & Rehabilitation for Addicted Prisoners) - This program is a therapeutic community for older, hard-core addicts with extensive criminal histories. The program provides treatment for 120 men annually, using two six-month cycles for 60 inmates per cycle. The program is a combination of educational/vocational training and therapeutic counseling. To be eligible, inmates must attain pre-release status and have MAP contracts. The program is honored at the Jessup Pre-Release Unit, and has an annual operating budget of $183,000. It is staffed with a half-time director, full-time educational coordinator and clinical director, three full-time addictions counselors, and a part-time consultant.

DIVISION OF CORRECTION

Substance Abuse Data

FY 1980

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I. Introduction

At both the Reception Center for Men (RDCC) and the Women's Institution (MCIW) the Addictions Program Staff attempt to test and screen in personal interview every new admission to the Division. The focus is on assessment of need and appropriate referral. The data that follow reflect findings from administration of the Mortimer/Filkins Questionnaire to groups of inmates at the time of admission, and subsequent individual screening interviews of those people who score positive for substance abuse on the Questionnaire. Logistics with respect to the Reception Center make it virtually impossible to either test or interview all admissions. However, it is believed the sample reached is representative.

II. Admissions and Testing

As indicated in the Table below 61.7 percent of all male admissions are given the Mortimer/Filkins Questionnaire.

Table I

* ADMISSION RATE AND SUBSTANCE ABUSE SCREENING, RDCC

Month	Admissions	Administered Mortimer/Filkins Questionnaire	Percent
July	477	222	46.5
August	397	221	55.6
September	299	135	45.1
October	336	239	71.1
November	351	191	54.4
December	308	146	47.4
January	337	207	61.4
February	324	215	66.3
March	319	269	84.3
April	386	245	63.3
May	364	291	80.0
June	296	206	69.5
TOTAL	4194	2588	61.7

* A substantial number (total not available) of these people are admitted "on paper" with services rendered at various facilities - P.G. Co., Patuxent, etc. Mortimer-Filkins Questionnaires are given only to those people admitted directly to RDCC.

III. Results of Mortimer/Filkins Testing

The Table below reflects that 70.4 percent of all men tested indicated positive for substance abuse.

Table II

*** MORTIMER-FILKINS TESTING, RDCC**

Month	Under 16 #	Under 16 %	16 - 23 #	16 - 23 %	24+ #	24+ %	TOTAL #	TOTAL %
July	74	33.3	83	37.4	65	29.3	222	100.0
August	66	29.9	83	37.5	72	32.6	221	100.0
September	42	31.1	46	34.1	47	34.8	135	100.0
October	73	30.5	94	39.3	72	30.2	239	100.0
November	45	23.6	76	39.8	70	36.6	191	100.0
December	38	26.0	54	37.0	54	37.0	146	100.0
January	53	25.6	87	42.0	67	32.4	207	100.0
February	77	35.8	69	32.1	69	32.1	215	100.0
March	71	26.4	89	33.1	109	40.5	269	100.0
April	66	26.9	87	35.5	92	37.6	245	100.0
May	96	33.0	96	33.0	99	34.0	291	100.0
June	67	32.5	66	32.0	73	35.5	206	100.0
TOTAL	768	29.6	930	35.9	889	34.5	2588	100.0

* Under 16 = generally no substance abuse problem
16 - 23 = high probability of substance abuse
24 plus = likely addiction

IV. Screening Interviews

Whereas the Mortimer/Filkins suggests tendency, in subsequent interviews it was found that 20 percent of those men with positive scores for substance abuse in fact reflected no history or pattern of abuse. Regardless, more than half of all male admissions would reflect substance abuse problems even with the adjustment following the screening interviews.

In the table below it is clear that men with substance abuse problems are more apt to abuse both alcohol and other drugs than to use either exclusively. This is consistent with findings of previous years.

Table III

* SUBSTANCE ABUSE SCREENING, RDCC

Month	Total	Alcohol	Other Drugs	Both	None
July	61	11	14	25	11
August	60	12	7	29	12
September	50	11	3	25	11
October	83	19	20	27	17
November	58	12	11	23	12
December	82	18	19	32	13
January	56	13	13	15	15
February	68	16	18	18	16
March	59	13	15	22	9
April	73	19	12	24	18
May	65	16	18	19	12
June	36	13	8	11	4
TOTAL	751	173	158	270	150
PERCENT	100.0	23.0	21.0	35.9	20.1

* These data are tabulated from personal interviews with men who score 16 or more on the Mortimer/Filkins Questionnaire.

V. Intoxication at Offense

The data in the table below are collected by self report of the men during the screening interview. They are consistent with findings of previous years.

Table IV

INTOXICATED AT OFFENSE, RDCC

Drug	Annually	1st Qtr (July - Sept)	2nd Qtr (Oct - Dec)	3rd Qtr (Jan - Mar)	4th Qtr Apr - June
ohol	202	58	57	42	45
ohol Plus:	161	37	49	40	35
mphetamine	8	2	3	1	2
arbituate	10	2	3	1	4
ocaine	6	2	2	1	1
eroin	11		6	2	3
SD	14		5	4	5
CP	30	14	9	4	3
alium	21	4	6	8	3
arijuana	54	13	12	16	13
ther	7		3	3	1
er Drugs Only:	134				
arbituate	5			1	4
ocaine	13	5	2	4	2
lue	7	2	3	2	
eroin	51	8	15	14	14
SD	2		1	1	
CP	12	2	2	3	5
alium	6		2	4	
arijuana	26	5	9	5	7

otal	497
otal Screened	761
ercent Intoxicated at Offense:	65.3%

Women and Substance Abuse

The data listed below are consistent with findings of previous years. Whereas about seven in ten men suggest substance abuse tendencies on the Mortimer/Filkins, women reflect similar tendencies in six of every ten tested.

Probably most importantly, women consistently reflect a penchant for drugs other than alcohol - 60.0 percent - while men affect alcohol more often.

SUBSTANCE ABUSE DATA, MCIW

Total Admissions to MCIW			277	
Mortimer/Filkins Testing			168	60.6% of Admission
Scoring:				
Under 16	62	36.9%		
16 - 23	65	38.9	) Positive for Substance Abuse	
24 Plus	41	24.2	) 106	63.1%
TOTAL	168	100.0%		
Screening Interviews:			103	(97.1% of Positives for Abuse)
Alcohol Only	16	15.5%		
Other Drugs	62	60.0		
Alcohol and Other Drugs	12	11.6		
No Problem	13	12.9		
TOTAL	103	100.0%		

DIVISION OF CORRECTION

SUBSTANCE ABUSE DATA

FY 1981, July-December

- - - - - -

I. At both the Reception Center for men (RDCC) and the Women's Institution (MCIW) Addictions Program Staff attempt to test and interview every new admission. Space and logistics generally make this impractical; and, the increasing numbers of men who are "walk throughs" (in only 24 hours or less), and are admitted to other facilities.

II. Admissions and Testing

Compared with FY 1980, our capacity to reach new admissions for testing has diminished at the rate of 50 percent. As indicated in the paragraph above, logistics and overcrowding are impacting negatively, profoundly on these services.

TABLE I

*ADMISSION AND SUBSTANCE ABUSE SCREENING, RDCC

Month	Admissions	Mortimer/Filkins Test	Percent
July	353	203	57.5
August	448	103	23.0
September	328	231	70.0
October	383	169	44.0
November	350	143	40.6
December	404	103	25.5
TOTALS	2266	951	42.0

*Mortimer/Filkins administered only to people admitted directly to RDCC; "walk thru" from Pre-Release Units, County Facilities, and Patuxent are not tested.

The results of administration of the Mortimer/Filkins Questionnaire in the last six months are comparable to previous findings.

TABLE II

*MORTIMER/FILKINS TESTING, EDCC

Month	Under 16		16 - 23		24+		TOTAL	
July	76		69		58		203	
August	34		36		33		103	
September	83		81		67		231	
October	56		62		51		169	
November	48		47		48		143	
December	24		52		27		103	
TOTALS	321	33.7%	347	36.3%	284	30.0%	952	100%

*Under 16 = generally no substance abuse

16 - 23 = high probability of problem

24 Plus = likely addiction

II. Screening Interviews

Whereas these findings are tempered by the numbers we have been able to screen, there is a definite shift in the DOC population to a more profound relationship with drugs other than alcohol. In Table III below this is much in evidence - - four out of every ten men reveal exclusive attachment to drugs other than alcohol, and 64.4% (almost two of every three) use "other drugs".

TABLE III

*SUBSTANCE ABUSE SCREENING

Month	Total	Alcohol	Other Drugs	Both	None
July	64	16	21	12	15
August	31	4	11	9	7
September	53	10	26	11	6
October	47	13	18	10	6
November	25	3	11	8	3
December	34	2	15	12	5
TOTALS	254	100.0% 48	19.0% 102	40.0% 62	24.4% 42	15.6%

*Personal interviews with men who score 16+ on Mortimer/Filkins

IV. Intoxication at Offense

Over several years, this factor has shown a remarkable consistency among those inmates screened in interviews. While one might assume there is a "secondary gain" element in the self report process given by the men, this writer believes the data are pretty accurate - - about seven in ten men report intoxication at offense.

TABLE IV

*INTOXICATED AT OFFENSE

Drug	Number	Percent
Alcohol	58	31.0
Alcohol Plus:	50	26.7
Amphetamines	4	
Barbituates	2	
Cocaine	1	
Heroin	6	
LSD	6	
Marijuana	10	
PCP	10	
Valium	4	
Other	7	
Other Drugs Only:	79	42.3
Amphetamines	1	
Barbituates	4	
Cocaine	5	
Glue	7	
Heroin	42	
LSD	1	
Marijuana	11	
PCP	2	
Valium	3	
Other	3	
TOTAL	187	100.0

*By self report of inmates

TOTAL:	187
TOTAL SCREENED:	254
Percent Intoxicated at Offense:	73.6

Women and Substance Abuse

The data listed below are consistent with previous findings.

SUBSTANCE ABUSE DATA, MCIW

July-Dec, 1980

Total Admissions:	116		
Mortimer/Filkins Testing:	96	82.7% of Admissions	
Scoring:			
Under 16	37	38.5	
16 - 23	42	43.7)	Positive for Abuse
24 Plus	17	17.8)	59 61.5%
TOTALS	96	100.0	
Screening Interviews:			
Alcohol Only	10	14.3%	
Other Drugs	42	60.0	
Both	7	10.1	
None	11	15.6	
TOTALS	70	100.0%	

Name: _____

QUESTIONNAIRE (FORM A)

INSTRUCTION: Before you begin, please print your name at the top of this page.

Please answer every question. Do not spend too much time on any one question. We would like your first impressions, so try to answer with the first thing that comes to mind. Answer each question in the order in which it appears. Mark an "X" or check (✓) for the TRUE (yes)/False (no) questions. Where you are asked to answer with a number, (how many) please put the number in the space provided. If the event never happened to you, mark zero (0). There are no right or wrong answers. Give the answer which seems most correct to you. Are there any questions now?

Go to the next page and begin.

QUESTIONNAIRE

FOR OFFICE USE ONLY

CASE ID
#_____

DATE_____

•1. What is your present marital status?

1. single
2. separated
3. divorced
4. widowed
5. married

Enter number here——————————————————(#) 221

2. With whom do you live?

1. alone
2. with friend (s)
3. with adult relative (s)
4. with wife (husband)
5. with ex-wife (ex-husband)

enter number here——————————————————(#) 222

IF YOU HAVE NEVER BEEN MARRIED SHIP TO QUESTION NUMBER 6

		TRUE (yes)	FALSE (no)	
3.	My wife (husband) has often threatened me with separation or divorce.——————	( )	( )	223
4.	How many times have you and your wife (husband) seriously considered separation or divorce in the last two years?——(#)			224
5.	My wife's (husband's) general health is (was) very good.—( )	( )		225
6.	I am employed now.—————————————( )	( )		226
7.	I smoke cigars or cigaretts.—————————————( )	( )		227
8.	About how many packs of cigars or cigaretts do you smoke per week?——————————————(#)			228
9.	I have been arrested at least once before this arrest.——( )	( )		229
10.	My family is upset with the way I live.—————————( )	( )		230
11.	The money I make is enough for my basic needs.—————( )	( )		231
12.	I am often nervous.—————————————( )	( )		232
13.	I make decisions better than I ever could.—————————( )	( )		233

QUESTIONNAIRE

		TRUE (yes)	FALSE (no)	
14.	I have had a very difficult problem recently (such as something concerning your job, your health, your finances, your family, or a loved one)———	( )	( )	234
15.	I sometimes have trouble forgetting about things that go wrong.(	)	( )	235
16.	I am sometimes so restless that I cannot sit long in a chair.—(	)	( )	236
17.	I am often sad or down in the dumps.———	( )	( )	237
18.	I sometimes wonder what I did the night before.———	( )	( )	238
19.	I have a lot of worries.———	( )	( )	239
*20.	I have trouble sleeping.———	( )	( )	240
21.	I am about average in all my habits (such as smoking, drinking, working).———	( )	( )	241
22.	I have problems that other people don't have.———	( )	( )	242
*23.	I have lived the right kind of life.———	( )	( )	243
*24.	My home life is as happy as it should be.———	( )	( )	244
25.	Drinking helps me make friends.———	( )	( )	245
26.	I often feel as if I have done something wrong or bad.———	( )	( )	246
27.	The people I owe money to are often too quick to bother me for payments.———	( )	( )	247
28.	I wish I could be as happy as other people are.———	( )	( )	248
*29.	I sometimes feel that I am about to go to pieces.———	( )	( )	249
30.	I usually sweat at night.———	( )	( )	250
31.	I often feel bad and down in the dumps.———	( )	( )	251
32.	About how many years has it been since your last out-of-town vacation? (If you have never taken one, write "9").———	(#	)	252
33.	I am a very nervous person.———	( )	( )	253
34.	I am happy with the way I live.———	( )	( )	254
35.	I have had my driver's license suspended or revoked before this arrest.———	( )	( )	255
36.	About how many times have you gone to someone (a counselor, a social worker, a doctor, etc.) for help for a problem (personal, family, marriage, money, or emotional)?———	(#	)	256

QUESTIONNAIRE

		TRUE (yes)	FALSE (no)	
37.	Someone in my family drinks too much.	( )	( )	257
38.	Someone in my family has or has had a drinking problem.	( )	( )	258
39.	I am often sad and gloomy.	( )	( )	259
•40.	I often feel as if I were not myself.	( )	( )	260
•41.	I am often afraid I will not be able to sleep.	( )	( )	261
42.	I often feel afraid to face the future.	( )	( )	262
•43.	Drinking seems to ease personal problems.	( )	( )	263
44.	How many drinks can you have and still drive well?	(#	)	264
45.	In the last year, how many times have you gotten drunk and still driven home safely?	(#	)	265
•46.	I wish people would stop telling me how to live my life.	( )	( )	266
47.	I often am afraid without knowing why.	( )	( )	267
48.	Sometimes I feel worthless.	( )	( )	268
49.	Sometimes I feel very guilty.	( )	( )	269
•50.	A drink or two gives me energy to get started.	( )	( )	270
51.	I work better when I've had something to drink.	( )	( )	271
•52.	My daily life is full of things that keep me interested.	( )	( )	272
53.	I often have felt restless without knowing why.	( )	( )	273
54.	My friends are much happier than I am.	( )	( )	274
55.	I often feel sorry for myself.	( )	( )	275
56.	Four or five drinks affect my driving.	( )	( )	276
57.	I feel tense and worried most of the time.	( )	( )	277
58.	I am often bored and restless.	( )	( )	278

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